STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00092628. Complaint IN00092628 substantiated. Federal deficiencies related to the allegations are cited at F323. Survey dates: July 11-15, 2011 Facility number: 000067 Provider number: 155143 AIM number: 100267880 Survey team: Laura Brashear, RN, TC Mary Weyls, RN Teresa Buske, RN Beth Kolasa, RN Census bed type: SNF/NF: 82 Total: 82 Census payor type: Medicare: 15 Medicaid: 48 Other: 19 Total: 82 Sample: 17	F0000	Please consider this Plan of Correction as our allegation of compliance. Disclaimer:Meadows Manor North Retirement and Convalescent Center, Inc. (Meadows) does not believe and does not admit that any deficiencies existed before, during or after survey. Meadows reserve all rights to contest proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Meadows reserves all rights to raise all possible contentions and defenses is any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correcting should be considered as a waiver or any potential applicable peer review, quality assurance or self critical examination privileges which Meadows does not waive and reserve the right to assert in any administrative civil or criminal claim, action or proceeding. Meadows offer its response, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to its residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Supplemental sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 7/20/11 by Suzanne Williams, RN			
F0314 SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure services were provided to prevent pressure areas for 1 of 3 residents reviewed with either a history of, or current, pressure ulcers in a sample of 17, in that a resident identified with pressure ulcers lacked pressure reducing devices. This deficient practice resulted in Resident #26 developing multiple stage 2 pressure ulcers. Findings include: During initial tour on 7/11/11 which began at 9:50 a.m. with LPN #2, LPN #2 indicated Resident #26 was dependant on staff for all needs and had a stage II area	F0314	It is the policy of the facility to ensure that a resident does not develop a pressure sore unless clinical condition demonstrates that it is unavoidable.Resident #26 was admitted with an unstageable pressure area and was placed on Low Air loss and Alternating pressure mattress to help prevent further breakdown. Per manufacturer recommendations the mattress can be set on weight or patient comfort. Resident #26 did not voice discomfort with the mattress setting. Upon notification that the pump was on the off position the matress was reinflated and an investigation began. A new mattress/pump was placed on the bed. Written statements from Lpn #2, #18 and CNA #3 state the	08/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to the right heel. On 7/11/11, during the initial tour which began at 9:50 a.m., with LPN #2, an alternating pressure mattress was noted on Resident #26's bed frame. The pump attached to the mattress indicated the mattress and pump was a "Static CVC low Air loss and Alternating pressure mattress." The pump was observed to be set at 350 on firm. During interview of LPN #2 on 7/11/11, during the initial tour which began at 9:50 a.m., LPN #2 indicated she was responsible for keeping track of any skin problems of the residents. The LPN indicated the unit nurses were responsible for performing treatments to open areas and she, LPN #2, measures the areas one time a week. The LPN indicated each resident receives a shower or full bath at least two times a week, and the CNA providing the care is responsible for filling out a shower sheet and identifying any skin issues the resident may have. LPN #2 indicated the completed shower sheets are given to the unit nurse who is working on the day the resident receives his/her shower and/or bath. The shower sheet is then given to the DON (Director of Nursing) and then to her (LPN #2). On 7/12/11 at 10:30 a.m., LPN #4 and		the mattress was not deflated while performing care to Resident #26. In addition, during shift change at 2pm on 7/13/11 the oncoming CNA's stated the bed appeared to be inflated. The pump was inspected by the maintenance department on 7/14/11. The maintenance department determined the motor of the pump was not functioning properly and could not be repaired therefore is no longer in use. A pressure reducing cushion was replaced in the wheelchair on 7/14/11 upon discovering it had been removed. A treatment order was obtained on 7/12/11 for the pinpoint area on buttocks. Maintenance inspected all air flow mattresses on 7/14/11 all other mattress were found to be in working order and properly inflated.Nursing staff were reeducated regarding verifying the proper settings and verify the mattess is inflated prior to exiting the room. Nursing staff was also reeducated regarding use of pressure reducing cushions. The unit managers will perform rounds at least 5x/week for the next 2 weeks to verify the air flow mattress and pressure cushions are in place. Then at least 3x/week for 2 weeks then 1x/week for 1 month and then randomly thereafter. Direct care staff will be immediately reeducated if any concerns are noted during rounds. Unit Managers will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA #3 provided care to Resident #26. The resident was observed in bed on her back and the staff repositioned the resident on her right side. An open area was noted on the resident's left buttocks. LPN #2 entered the room and observed the area on the left buttocks. The resident was then repositioned to her left side and a large red area was noted on the resident's right hip with a dark purple area in the center. LPN #2 indicated to CNA #3 to place a cushion in the resident's wheelchair, prior to getting the resident up. During interview of LPN #2 on 7/11/11 at 11 a.m., the LPN verified she was unaware of these areas. The LPN indicated she had checked the shower sheets from the day before concerning Resident #26, and the shower sheets did not indicate any skin issues other than the left heel. On 7/12/11 at 1:40 p.m. Resident #26 was observed sitting in a wheelchair. The resident was sitting on the sling type seat of the wheelchair. A cushion was lacking. At 3 p.m., and 4 p.m., the resident was observed to be in the wheelchair without a cushion. At 4 p.m., the resident was observed to be leaning toward the right with right hip resting against the metal side piece of the wheelchair.		inform members of QA committee in morning meeting of any areas of concern.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 7/13/11 at 9:55 a.m., and 11:35 a.m., Resident #26 was observed in a wheelchair, with a sling seat, without a pressure relieving cushion. At 12:30 p.m. the resident was observed to be propelled, while in the wheelchair, from the lounge to the dining area. During interview of CNA #3 at 11:45 a.m., the CNA indicated the resident did not have a cushion in her wheelchair. On 7/13/11 at 1:10 p.m., LPN #2 and CNA #3 transferred Resident #26 from a wheelchair to the bed. The sling seat of the wheelchair was observed not to have a cushion. The alternating mattress was observed to be deflated. The on-off switch on the pump was observed to be in the off position. The staff left the room without attempting to inflate the mattress. At 2:30 p.m., LPN #18 performed a treatment on Resident #26's heel. During the treatment, the mattress was noted to be deflated. The LPN left the room without attempting to turn the mattress on. The on-off switch on the pump was observed to be in the off position. At 3:35 p.m., LPN #2 was summoned to Resident #26's room. LPN #2 indicated the resident's alternating mattress was deflated and was turned off. The LPN switched the mattress to an on position			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and the mattress began inflating. During interview of LPN #2 on 7/14/11 at 4:15 p.m., the LPN indicated she had found a new pressure area on 7/14/11 on the resident's right buttock. Resident #26's clinical record was reviewed on 7/12/11 at 11:20 a.m. An admission date was noted of 6/8/11. A nursing assessment indicated the resident was admitted with an unstageable pressure area on the left heel. An initial RAI (resident assessment instrument) was noted, dated 6/17/11. The assessment indicated the resident was at risk for further pressure ulcers due to impaired mobility and documented that pressure reducing devices were to be utilized on the resident's bed and chair. The following wound/skin healing records were provided on 7/14/11 at 4:15 p.m. from LPN #2; Wound sheet indicating an onset date of 7/12/11, of an unstageable purple pressure area on the resident's right hip measuring .4 X .5 cm. Wound sheet indicating an onset date of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7/12/11, of a stage II pressure ulcer on the resident's left buttock measuring 1.5 X .8 cm with less than .1 cm in depth Wound sheet indicating an onset date of 7/14/11 of a stage II pressure ulcer on the resident's right buttock measuring .2 X .2 cm. A facility policy titled "SKIN CARE MANAGEMENT" received on 7/15/11 from LPN #2, indicated "Preventative measures will be established and implemented for all residents assessed as moderate to high risk for pressure sore development (using the Braden Scale) including but not limited to a. Pressure-reducing mattress/overlay b. Pressure reducing cushion in chair...." 3.1-40(a)(2)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation and record review, the facility failed to ensure a resident with an indwelling Foley catheter received	F0315	It is the policy of the facility to all catheter tubing off the floor to help prevent infection.Resident #11 was not harmed from the	08/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	services to prevent urinary tract infections, i.e. keeping catheter tubing off of the floor, for 1 of 2 residents reviewed with Foley catheter in sample of 17. (Resident # 11) Findings include: On 7/11/11 at 11:10 a.m., Resident #11 was observed to have Foley catheter. On 7/12/11 at 9:40 a.m., Resident #11 was observed to be positioned in wheelchair in lounge area with Foley catheter tubing lying on the floor. On 7/14/11 at 3:15 p.m., Resident #11 was observed to be positioned in wheelchair in lounge area with Foley catheter tubing lying on the floor. Review of the clinical record on Resident #11 on 7/13/11 at 12 p.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 5/13/11. The MDS identified the resident with urinary tract infection in the last 30 days and utilizing indwelling catheter. A physician's order was noted dated 6/13/11 of Ceftin (antibiotic) 250 milligram by mouth twice daily for 10 days for urinary tract infection. The resident's current plan of care addressed the problem of Resident requires use of foley catheter related to		alleged incident. All residents with catheters were assessed for proper positioning of the catheter tubing.All nursing staff were reinserviced regarding proper catheter tube placement. Unit Mangers will perform rounds at least 5 days per week for the next 14 days, then 3x/week for 14 days, then 1x/week for 1 month, then randomly thereafter to ensure compliance. The unit managers will report their observations to the Infection Control/Quality Assurance nurse weekly. The QA nurse will report there finding to the Quality Assurance committee at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	urinary retention and renal failure dated 3/14/10 and revised 5/11. The approaches included but were not limited to keep foley catheter bag and tubing off the floor. Review of facility's current policy and procedure titled "Routine Foley Catheter Care" dated 8/05 on 7/15/11 at 3:35 p.m. indicated "...8. Ensure catheter drainage bag is kept covered and not allowed to touch the floor when resident is up in chair. " 3.1-41(a)(2)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to safely provide mechanical lift transfers in accordance with manufacturer's directions for 3 of 4 residents in a supplemental sample of 8 [Residents F, B, and G] and 1 of 1 resident in a sample of 17 [Resident D] observed transferred with mechanical lifts; and failed to implement approaches to prevent falls for 1 of 2 residents in a supplemental sample of 8 [Resident A] and 1 of 6 residents [Resident C] in a sample of 17 reviewed for falls.	F0323	It is the policy of the facility to ensure the resident environment remain as free of accidental hazards as is possible. Resident A B, C,D,E,F were not harmed by the alleged incident. All nursing staff were inserviced regarding the correct use of the mechanical lifts such as the proper height during transporting a resident and also the proper position of the chassis legs. All nursing staff performed return demonstation of their knowledge of proper use the lifts. All nursing staff were also reinserviced regarding the use of	08/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. Resident A's clinical record was reviewed on 7/14/11 at 3:30 p.m. The resident's diagnoses included, but were not limited to: convulsions, anxiety, Alzheimer's dementia, cardiac disease and diabetes. A nurse's note, dated 6/22/11 at 1:40 a.m., included, but was not limited to, "Notified of res. [resident] being on floor @ [at] this time. CNA reports she responded to bed alarm sounding. Upon entering room res. was attempting to get OOB [out of bed] to wheelchair. CNA states she assisted res. to w/c [wheelchair] et [and] told her to 'Hold on' while she retrieved linens d/t [due to] res bed being soiled with urine. Res. was in w/c with shoes on when CNA left room. CNA heard noise from res room et [and] went in to find res on back on floor in BR [bathroom] with head under sink et urine on bathroom floor. CNA notified nurse @ this time. Res was on floor with head et shoulders under sink area. Res alert. Reports 'I slipped.' Res noted with elevated area to back of head, approx [approximately] 3 cm [centimeters] long et 1.5 cm wide. Res. bleeding. After cleaning hair, res noted to have small laceration, approx 0.5 cm to middle of elevated area. ..."		the safety alarms. Nursing staff was reinstructed regarding the use of the their assignment sheets which states the proper assessed alarm. Nursing staff was reminded to verify alarms are on and working properly prior to leaving a resident after performing care. In order to ensure compliance the unit managers or designee will observe at least 3 transfers per week for the next 4 weeks then at least 1 transfer per week for the next 4 weeks then at least 2 per month thereafter. The unit managers will review their findings with the DON. Any nursing staff observed not following proper technique will be reinserviced by the eduation director. The education director will report to the Quality Assurance committee quarterly any issues or concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A hospital emergency record, dated 6/22/11 at 3:51 a.m., indicated documentation included, but was not limited to, "Patient...comes to the emergency department after a fall at nursing home just prior to arrival. She states she was going to the bathroom and slipped on a wet bathroom floor which caused her to fall. ...has small hematoma to occipital area of scalp. No area of laceration or bleeding noted. ..." A Minimum Data Set [MDS] completed on 5/12/11 coded the resident with severe cognitive and memory impairments, required moderate assistance of 1 for transfers and ambulation. A plan of care addressed the problem of potential for injury from fall with most recent goal date of August, 2011. Approaches included, but were not limited to: pad alarm in chair and pressure alarm in bed, dated 4/6/10. Physician's orders were noted dated 4/25/10 for "may use bed and chair alarms for safety. Check alarms every shift for placement and function." LPN #16 was interviewed on 7/14/11 at 5:30 p.m. The LPN indicated she was responsible for investigating and tracking falls. The LPN indicated after Resident A had been assisted from the bed into the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wheelchair, the chair alarm was not implemented. The CNA exited the room to obtain linens, and the resident was not assisted to the bathroom prior to leaving the room. 2. During initial tour on 7/11/11 at 11:00 a.m., with the Minimum Data Set [MDS] coordinator RN #17, Resident C was identified with confusion at times, history of falls, and utilized bed and chair alarms. LPN #16 was interviewed on 7/12/11 at 2:10 p.m. LPN #16 was identified as responsible for investigating and tracking falls. The LPN indicated Resident C had five falls after admission to the facility. The LPN indicated the resident now utilizes a self-release alarmed safety belt while in the wheelchair. Resident C's clinical record was reviewed on 7/13/11 at 1:10 p.m. An admission date was noted of 6/24/11. The resident's diagnoses included, but was not limited to, cerebral vascular accident, dementia, left hemiparesis, and history of falls. An admission Minimum Data Set [MDS] assessment, completed on 7/11/11 coded the resident with severe cognitive impairment, required extensive assistance of two for transfers and ambulation, one fall since admission. Physician's orders			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were noted dated 6/24/11 for bed and chair alarms, check proper placement and functioning every shift. Documentation was noted in a nursing note, dated 6/28/11 at 3:30 a.m. of on floor, no alarm sounding resident had removed gown. A plan of care, dated 6/24/11 addressed the problem of at risk for falls secondary to decreased mobility. Approaches included, but were not limited to, bed pressure alarm, dated 6/24/11. On 7/15/11 at 11:30 a.m., LPN #16 was interviewed. The LPN indicated a clip alarm had been utilized on the resident at the time of the fall and the resident had removed clothing which prevented alarm from working. The LPN indicated the resident was planned to utilize a pressure pad alarm in bed, and did not know why it had not been implemented. 3. On 7/13/11 at 3:00 p.m., Resident B was observed to be transferred from the wheelchair to bed with the Arjo Maxi-lift by CNAs #5 and #6. After positioning the resident on the sling lift, the base of the lift was opened around the resident's wheelchair and the sling attached. The resident was raised off of the wheelchair seat. The lift was pulled away from the wheelchair, and the legs of the base closed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	slightly. The arrow of the indicator on the mast of the lift was observed to be on the high area of the red coloring on the mast. Resident B's clinical record was reviewed on 7/14/11 at 4:50 p.m. The most recent MDS [Minimum Data Set] assessment, completed on 5/7/11 coded the resident as requiring extensive assistance of two for transfers. A care plan with most recent update, dated 5/11 included the approach to utilize a hoyer mechanical lift with assistance of two for transfers. 4. On 7/12/11 at 10 a.m., Resident D was observed to be transferred from the bed to the shower chair utilizing the "Arjo" mechanical lift by CNAs #11 and #12. The resident was observed to have legs extended with spasms. The resident was unable to relax to sitting position in the shower chair. The CNAs were observed not to support the resident's extended legs. As CNA #12 pulled the resident towards the back of the shower chair, the resident was observed to relax to a sitting position. The shower chair was observed not to be a reclining shower chair. On 7/12/11 at 10:25 a.m., Resident D was observed to be transferred from a non-reclining shower chair to wheelchair utilizing the "Arjo" mechanical lift by CNAs #11 and #12. The resident was observed to be lifted from the shower with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the base of the mechanical lift to be open. The resident was transported in the lift with the base of the lift open. The resident was positioned in the wheelchair. Review of the clinical record of Resident D on 7/14/11 at 11:40 a.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 5/3/11. The resident was denitrified as requiring extensive assistance with transfers. The CNA assignment sheet dated 7/14/11 indicated the resident was to be transferred with the "Arjo" lift and to use reclining shower chair. 5. On 7/13/11 at 2:05 p.m., Resident F was observed to be transferred from the wheelchair to bed utilizing the "Arjo" mechanical lift by CNAs #9 and #10. The Resident was lifted from the wheelchair with the base open. The base of the lift remained opened while the resident was transported to the bed. Review of the clinical record of Resident F on 7/14/11 at 6 p.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 3/29/11. The assessment identified the resident as requiring extensive assistance for transfers. The CNA assignment sheet dated 7/14/11 indicated the resident was to be transferred with the "Arjo" lift.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEN	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6. On 7/14/11 at 2:40 p.m., Resident G was observed to be transferred from the geri-chair to the shower chair utilizing the "Arjo" mechanical lift by CNAs #9 and #10. The resident was lifted from the geri-chair with the base open . The base remained open while the resident was transported to the shower chair. The height of the lift was in the "red" area. The resident was transported at this height. The resident was toileted. The CNAs then lifted the resident again with the "Arjo" mechanical lift from the shower chair. The base was open and remained open as the resident was transported back to the geri-chair. The base was closed slightly going through the doorway during transport; however, the legs were not parallel. Review of the clinical record of Resident G on 7/15/11 at 11:30 a.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 5/7/11. The assessment identified the resident as requiring extensive assistance for transfers. The CNA assignment sheet dated 7/14/11 indicated the resident was to be transferred with the "Arjo" lift. Review of the "Arjo Maxilift" manufacturer's guidelines on 7/14/11 at 10:20 a.m. indicated "....Transport always			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with parallel chassis legs...During transportation turn the patient to face the operator and keep at normal chair height-this gives confidence, dignity, and also improves the Maxilift mobility...Patients with extensor spasm may be lifted by Maxilift but special attention should be paid to supporting the legs during the early part of the lift...Patient transport must only take place when the chassis legs are parallel and the hoist is at its correct transportation height. Always make sure that the height indicator is within the green area during transport." This federal deficiency is related to Complaint IN00092628. 3.1-45(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure ice utilized by residents was stored under sanitary conditions for 1 of 1 general observations tour in that a pink substance was observed on a plastic part of the inner part of the ice machine. This had the	F0371	It is the policy of the facility to ensure the ice utilizied by residents is stored under sanitary conidions.The ice machine was cleaned by Maintenance staff on July 18, 2011. The plastic part remained discolored. The Maintenance supervisor has ordered a replacement piece for	08/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	potential to affect 80 of 82 residents in the facility. Findings include: During general observations tour on 7/15/11 which began at 11:30 a.m., with the Maintenance supervisor and Maintenance staff #15, the ice machine utilized for the residents was observed with a pink substance on a plastic part of the inner ice machine. The maintenance person wiped the plastic part of the ice machine with a paper towel, and a small amount of the pink substance was noted on the surface. During interview of the Maintenance Supervisor on 7/15/11 during the general observation tour which began at 11:30 a.m., the Maintenance Supervisor indicated the maintenance department was responsible for cleaning and sanitizing the ice machine on a monthly basis. During interview of the Maintenance Supervisor on 7/15/11 at 12:45 p.m., the Maintenance Supervisor provided a log titled "MONTHLY ICE MACHINE CLEANING CHART" , the chart indicated the ice machine had not been cleaned since 4/11/11. The Maintenance Supervisor indicated there had been some changes with the maintenance department		the ice machine. In order to ensure the ice machine is properly cleaned the Dietician will inspect the ice machine weekly for the next 4 weeks and monthly for the next 12 months. She will report to the administrator any area of concern. The dietician will also report her findings at least quarterly to the quality assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH RETIREMENT AND CONVALESCEI	3150 N SEVENTH ST TERRE HAUTE, IN47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and the ice machine had been overlooked. 3.1-21(i)(3)			